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Consumer and Provider Feedback at the Local Level

Prepared for:
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Truth is forever absolute, but opinion is truth filtered through the moods, the blood, the disposition of the spectator.

Wendell Phillips

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Executive Summary

This report describes feedback from consumers and providers in each of the twenty-five Local Management Entities (LME), collected during January and February 2008 as a companion task to the LME performance review conducted by the Mercer Group. As such, the report offers narratives of the individual experiences to supplement the data collected by the Mercer Group, and it is intended to give local flavor in telling the story of how consumers and providers fare as the system transformation enters its seventh year of implementation. In order to preserve the integrity of the Mercer review, no recommendations related to the individual LMEs are made in this report.

The data collection derives from twenty-six focus groups with providers (one acute hospital sample was added) and twenty-four focus groups (no show for one site) with consumers, held on-site at twenty-five different locations in North Carolina. Altogether, 166 provider staff and 130 consumers participated in the discussions and lent their time and energy to the task. Their level of cooperation is proof that getting the reform on track is a shared commitment.

Structured focus group questions were developed for the consumer and provider groups as outlined below:

Consumer Focus Group Questions by domains:

- Communication (ongoing communication about service array, consumer rights, availability of providers, and feedback about the services)
- Access (screening, triage, and referral)
- Services (actual services received and tenure)
- Crisis and emergency needs
- Appeals and individual experiences with complaints and grievances
- Quality and service outcomes (different questions for different disability groups)

Provider Focus Group questions by domains:

- Communication (ongoing communication about service network, changes in rules and procedures, endorsement and authorization, other interactions)
- Access (screening, triage, and referral)
- Services (types of services provided, gaps, and new service development)
- Endorsement and contracting
- Utilization review and utilization management
- Appeals
- Provider monitoring

Major findings from the consumer and provider feedback:

1. With few exceptions, consumers receiving services are generally pleased with how the services have improved their lives; however, adult consumers with severe and persistent mental illness (SPMI) or severe addiction problems continue to have access problems.
2. Consumers have identified service gaps in supported housing, supported employment, psychiatric services, and crisis interventions that can help to avoid out-of-home placement for children and hospitalization for adults, including such services as in-home crisis stabilization, emergency respite, mobile crisis team, and 24/7 availability of crisis response.
3. Providers are more receptive to serving Medicaid-eligible consumers than consumers with IPRS funding (for those without Medicaid eligibility). Many providers have chosen to not serve IPRS-funded consumers, and this trend is disturbing.
4. Providers have praised the LMEs for timely communication, provision of training, and technical assistance. Providers that primarily serve a single LME area tend to be satisfied with the LME's practice. However, providers covering multiple LMEs have universally expressed their frustration with inconsistency and lack of standardization among LMEs in endorsement, IPRS authorization and payment, and provider monitoring.
5. Providers are concerned about the paperwork requirements placed for access to be completed, and services to be authorized and reauthorized.

Some general observations from the field and additional questions are offered for the considerations of policymakers:

It is commonly known that since 2001 there has been a dramatic growth in the provider network and an increased number of consumers served, but the jury is still out on whether such growth has advanced the objectives of the reform. It also seems that the state's targeted populations are competing with other consumers with Medicaid eligibility for access to enhanced services, and there are barriers to obtaining Medicaid eligibility for the state's targeted populations, especially consumers with severe and persistent mental illnesses. Finally, there is a lack of development of evidence-based practices, which raises the question of competency and qualifications of providers in the system, and what steps should be taken to nurture such development.

I. Introduction

This report describes feedback from consumers and providers at the local level in twenty-five Local Management Entities (LMEs) areas throughout North Carolina. It is intended to supplement the review conducted by the Mercer Group, an outside consulting firm engaged by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) to provide an independent performance review of each of the twenty-five LMEs in carrying out their functions of planning, managing, and overseeing public mental health, developmental disabilities, and substance abuse services.

The feedback from consumers and providers is obtained independently by this consultant to serve a set of objectives. It aims to bring in perspectives of consumers and providers, to explore their individual experiences and seek their input into the ongoing improvement of the public system. It is conducted in a way that allows sharing of individual stories and opinions to produce qualitative narratives that will complement the quantitative database collected by Mercer. It is designed to offer findings but not specific recommendations in order to preserve the independence of the Mercer review. The summary of findings—including observations made on the road—attempts to provide the local flavor and insight into what takes place at the level that matters the most: between consumers and their providers, and the interplay among consumers, providers, and LME staff. To the extent that these interactions are affected by activities at the state level, they are noted in the report.

The feedback was collected in the field from late January to late February 2008, in each of the twenty-five LME areas. Altogether fifty focus groups (166 provider staff and 130 consumers) were conducted—twenty-four for consumers and twenty-six for providers—at sites where the providers and consumer are present, instead of convening focus groups in a neutral location. This single snapshot approach, while efficient in logistics, has its limitations of not being able to cover a wide group of consumers and providers in each of the LMEs. However, the limitations of going to a single provider are compensated by having sufficient diversity in the state sample, and the benefit of gathering additional

information from providers who have contractual relationships with multiple LMEs so that cross-checking of feedback from more than one provider regarding the same LME, is possible. Additionally, visiting providers and consumers on program site provides a "feel" about the environment, and the opportunity to observe interaction between providers and consumers that would not have been possible had these focus groups been held on neutral sites.

The report outlines methodology used to gather feedback from consumers and providers, strengths and limitations of the methodology, and means for compensating for the limitations. General patterns of consumer and provider feedback are given, followed by specific comments by the participants. The summary of findings turns from individual experiences to a statewide perspective that can lend to further discussion and policy recommendations. In the last section on field observations, the report touches on areas that either are noteworthy or require additional information.

II. Methodology

Several methods are available to gather feedback from providers and consumers. Indeed, there have been systematic collections of input from these key stakeholders in local, regional, or statewide surveys—performed by internal and external entities—and findings have been made available to the public.[1] In these prior efforts, phone, electronic or paper surveys, and selected focus groups have all been tried.

In approaching the current task of collecting qualitative data about consumer and provider feedback to complement the Mercer review, there are new considerations:

- The window of opportunity is limited and the data need to be available prior to March 2008.
- Given Mercer's on-site review of LME functions during January 2008, there is a desire not to impose an additional burden on LME management and staff. Thus their involvement must be minimal.
- Reaching consumers represents a challenge given the wide geographical spread of services in North Carolina and lack of transportation means for many consumers.

Given these considerations, this consultant proposed a single site to hold both provider and consumer focus groups in each of the twenty-five LME areas. By going to "where people are," the consultant was able to schedule all visits to meet the deadline of completing a report by the end of February. There are many advantages to this approach:

- It preserves the tenets of the focus group method by repeating a set of questions at multiple sites and uses the group discussions to produce nuanced and qualitative data.
- It solves the logistical problem of travel for consumers and providers.

[1] Examples: *The North Carolina Consumer Satisfaction Survey*, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, October 2007; *North Carolina MH/DD/SAS Workforce Analysis Project*, conducted by Behavioral Healthcare Resource Program, School of Social Work, University of North Carolina at Chapel Hill, August 2007.

- It has the added value of allowing observations about the service environment, to get a "feel" for the place where consumers receive services that would not be available when the focus group is held at a neutral site.

However, there are limitations to this method:

- There is a high likelihood of getting a slanted view from a single provider that may not represent the feedback of the entire provider network in a given LME area.
- Selecting one provider per LME may not represent services to consumers with multiple disabilities or different age groups.
- This method—in fact most consumer survey methods—presumes that the consumers are already in services, thus precluding those with access problems.

The following efforts were made to remedy the limitations noted above:

- Although a single provider site is chosen for each LMEs, most providers cover multiple LMEs, so some cross-checking on responses is possible.
- To ensure sufficient diversity and representation, the total sampled providers include services to consumers with multiple disabilities and different age groups.
- Though consumers outside the system could not be included in the data collection, attempts were made during the focus group interviews to query consumers who may be aware of others having difficulty accessing services.

The steps to selecting consumers and providers for the review are described below:

- The consultant obtained a statewide provider directory from the Division and made an initial selection.
- Each LME was consulted on the initial selection, and substitution was accepted based on new information (ex: provider going out of business), or lack of consumer base (ex: a new provider with only two consumers enrolled), or suggestion of a multiservice provider to replace a single service provider selected.
- Each LME notified the selected provider, to be followed by the consultant to schedule a visit.

- Orientation to the selected provider in terms of the purpose of the visit and availability of consumers for focus groups on the date of the visit; the consultant informed each provider that the gathering would be "ad hoc" using "whoever is available" as a criterion, and that there would be no attribution of opinions shared in the report to preserve confidentiality.
- Focus groups were held and data collected using focus group questions and protocols developed prior to the visit.

To standardize data collected, a set of questions were developed for consumer and provider focus groups (Appendix I). These questions covered areas of inquiry used by the Mercer team to facilitate the comparative analysis between quantitative and qualitative data, and the focus group questions were shared with the Division and the Mercer Team before these site visits.

Consumer Focus Group Questions by domains:

North Carolina Local Management Entity Consumer Focus Group Questions

Domain	Focus Group Questions	Follow-up Questions
Communication (ongoing communication about service array, consumer rights, availability of providers, and feedback about services)	● Are you fairly familiar with your rights? Have you received information about this? ●Do you have information about services available in your county? ●Have you been asked about your view on the services received (phone calls, interviews, or written surveys) by the LME?	√If consumer satisfaction survey has been conducted, identity the originator (provider or LME). √Explore the degree of knowledge about CFAC and Client Rights Committee
Access(screening, triage, and referral)	● Were you referred to the services through LME? How? ● If you called the access line, how long did it take for you to receive assistance? ● If you used other means (walk-in, family or friend, provider), please describe the process. ●Did you experience any problems? If so, please describe them ●Do you have any suggestions about how to improve consumer access?	√ Tenure of being in the service system √ Tenure with the current provider √ Note if consumer enters services directly provided by LME
Services (planning and delivery)	●What services are you currently receiving? ●Did you participate in the person-centered planning? How? ● In addition to this program, do you receive services from other providers? If so, describe them ●What is your most critical service need? ●Do the services you have received meet this critical	√ Identify service gaps √ Identify services barriers √ Identify positive and negative experiences √ Identify services directly provided by LME

	need? ●Do you feel you have been treated with courtesy and respect?	
Crisis and emergency needs	●Do you know where to go in case of crisis (in mh/dd/sas)? ● Do you use informal help (friends and families, civic and religious organizations)? ●Have you had any personal experiences with crisis or emergency that you require professional help? Please describe them.	√ Explore when the crisis services were made available √ Explore the types of crisis services available √ Explore consumer feedback for services received
Appeals	● Do you know where to go if you have a concern or problem about the services you receive? Please describe the process ● Have you complained to LME about the services you received? What was the result? ● Have you gone through any formal complaint and grievance procedures? What was it like? What was the result? ● What suggestions would you have about improving the process?	√ Explore each individual experience to identify whether the complaint/grievance was directed at the provider and/or LME level.
Quality and Service Outcome	●Do you feel you are progressing in your own recovery goals (for mh/sa consumers)? Please explain. ●Do you feel you are progressing in your habilitation goals (for dd consumers)? Please explain. ●What expectations do you have for yourselves and for the providers (for mh/dd/sa consumers)?	√ Explore the consumer's prior history in service outcomes to compare current feedback about service outcomes √ Explore individual stories about what helped in the past, and what can help now

Provider Focus Group questions by domains:

North Carolina Local Management Entity Provider Focus Group Questions

Domain	Focus Group Questions	Follow-up Questions
Communication (ongoing communication about service network, changes in rules and procedures, endorsement and authorization process)	● How are you informed about the array of services needed in the LME area? ● Is there a mechanism for you to receive ongoing communication about state and local rules and practices, funding possibilities? ●When and how were you enrolled in the provider network? Did you go through any RFP process?	√If other parties other than the LME have been providing information, identify them. √Explore communication mechanisms (manual, bulletin, meetings, etc.) √ Differentiate providers of mh/dd/sa services
Access(screening, triage, and referral)	● What is the percentage of consumers that entered your services without going through the STR at the LME level? ● Do you notify the LMEs when a consumer enters your service without a direct referral from LME? ● For individual mh/dd/sa providers: How is the access different for the disability groups you are serving? ●Did you experience any problems with consumer enrollment? If so, please describe them ●Do you have any suggestions about how to improve consumer access?	√ Tenure of being part of the provider network √ Whether or not the provider serves multiple LMEs √ Note whether the consumer is referred to services directly provided by the LME
Services (planning and delivery)	●What services are you currently providing? ● In addition to this program, do you provide other types of services? If so, please describe them	√ Identify service gaps √ Identify barriers to providing services`

	●What do you expect your services to achieve for consumers?	√ Identify positive and negative experiences √ Explore any development of evidence-based practices
Endorsement and contracting	●Please describe the process by which you were endorsed to provide services. Did it include more than a paper review? ● Please describe the contracting process with the LME or LMEs and note the differences among the contracting if any.	√ Explore positive and negative experiences √ Explore differences among LMEs if the provider has presence in multiple LMEs or if the LME provides services directly
Utilization Review/Management	●Do you provide both Medicaid funded services and state funded services? For each, please describe the utilization review/management process ● If you provide services to more than one LME, please compare how each of the LMEs deals with utilization review	√ Explore differences among LMEs if the provider has presence in multiple LMEs √ Explore how the LME deals with UR for services it provides directly
Appeals	● Are you familiar with the provider appeals and grievances procedures? ● Have you used the process to appeal or grieve to the LME? What was the result? ● If the provider is serving multiple LMEs: Can you describe the similarities and differences of approaches used by each of the LMEs you deal with? ● What suggestions would you have about improving the process?	√ Explore individual experiences, methods, and results √ If the appeals are related to problems with claims payment, get the details
Provider monitoring	●How are you monitored? Please explain. ●Where are you now in terms of your compliance level as a provider? ●How long have you been a provider for the county/region? ●Will you continue to be a provider? Do you have any plans for expansion?	√ Explore the methods, process and procedures of provider monitoring and how problem areas have been dealt with √ Explore whether the providers are new (post-reform) or old (pre-reform)

III. The Sample

It is generally believed at the state and local levels that the system transformation since 2001 has had the least impact on the developmental disability system. It was questioned whether this consultant should select DD providers in the information gathering for this project. However, if the full functionality of LMEs is to be assessed, the DD system cannot be left out of the review. Thus a limited DD consumer and provider sample is included to shed light on how LMEs carry out functions related to the DD providers and consumers, albeit the sample size is the smallest among the three disability groups.

To arrive at the selection of the focus groups, this consultant went to the state data bank to obtain the total providers in the public MH/DD/SAS system for an initial selection. As of December 2007, there were over 3500 community providers in North Carolina,[2] representing a huge growth since 2001. Selection of provider sites for the focus groups should thus be viewed in this context: for every provider included, there are many more providers not included. This context applies to consumers included in the focus groups as well.

The Participants

Provider staff that participated in the focus groups share general characteristics, such as a cross-section representation of management: staff who have the most active involvement with the LMEs and staff with direct interaction with consumers, including community support and psychosocial rehabilitation staff. On occasion, the provider/consumer roles were blurred when a staff could also be a consumer, or a consumer is functioning as a provider, i.e., peer specialist. One psychiatrist was included in a focus group discussion through an interactive telecommunication system.

For consumers, children were often accompanied by adult parents or foster care parents, and DD consumers were accompanied by parents in some cases. There was a balanced

[2] Data source from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, January 2008.

representation of racial and ethnicity in the consumer sample; however, the minority consumers were primarily African American, and there was only one Hispanic consumer and two Asian consumers in the sample.

Table 1. Number of Consumers and Staff in the Focus Groups

LME	Consumer	Provider	Total
Alamance-Caswell-Rockingham	3	5	8
Albemarle	2	3	5
The Beacon Center	7	8	15
Catawba County	10	6	16
Center Point	4	8	12
Crossroads	2	3	5
Cumberland	9	6	15
Durham	7	9	16
East Carolina	2	12	14
Eastpointe	7	4	11
Five County	1	4	5
Foothills*	1	4	5
Guilford	0*	7	7
Johnston	8	5	13
Mecklenburg	11	8	19
Orange-Person-Chatham	3	5	8
Onslow-Carteret	5	6	11
Pathways	4	5	9
Piedmont	8	7	15
Sand hills	10	7	17
Smoky Mountain	8	7	15
Southeastern	8	5	13
Southeastern Regional	2	5	7
Wake	4	14	18
Western Highlands	4	5	9
Acute Care Hospital**	n/a	8	8
Total	130	166	296

* Will be merged with Smoky Mountain as of July 1, 2008
** This is an unique sample

Types of Providers

Providers included in the sample have had different tenure in the system; some were clearly created after 2001, either as a spin-off or as a new private provider, others have had longer history in the state. Others are generic human service providers, providing services not only to the MH/DD/SA system, but also to other service systems such as social services and juvenile justice. Providers in terms of types of services rendered and nature of incorporation are shown in Tables 2 and 3.

Table 2. Types of Services Provided

Types of Providers	Number
Children and Youth MH/SA/DD	3
Adult and Children MH/SA	4
Adult and Children MH/DD/SA	5
Adult MH	5
Adult SA	3
Adult MH/SA	1
Adult MH/SA/DD	1
DD provider	2
Facility-based crisis services	1
Acute Hospital (emergency and acute care)*	1
Total	26

*This is a special selection outside the 25 providers selected for the LMEs

Table 3. Nature of Incorporation*

Nature of Corporation	Total
Not-for-Profit	17
For-Profit	9
Total	26

*No judgment is made about the nature of the incorporation.

Number of LMEs Covered

The majority of providers in the sample cover more than one LME areas, and the multiple LMEs contracts with the same provider range from two to fourteen.

For those providers that contract only with a single LME, there are occasions when a small number of consumers from other LMEs are served by the same provider. This is true when the services are either under-developed or not available in the referring LMEs.

Table 4. Number of LMEs Covered

Number of LMEs Covered	Number of Providers
1	8*
2 to 5	9
6 to 9	5
10 to 14**	4
Total	26

*Even providers covering one LME may occasionally take in referrals from other LME areas.

**Some in this category have corporate responsibility for large number of LMEs covered, and could provide comparative analysis of different LME practices.

IV. Consumer Feedback

Several basic assumptions can be made about gathering consumer feedback on the program site. First, there is a general tendency for consumers to give positive feedback about the services. Second, there might be a natural selection on the part of the participants—those agreeing to participate in the focus group might be inclined to support the services. Third, there might be some concern, despite the assurance from the group moderator, that any negative comments about the services could affect the consumer's ongoing relationship with the providers.

To counteract these natural and understandable tendencies, the queries went beyond simply whether the consumers were satisfied with the services received. Questions included whether the services address "the critical need" in their lives, and whether they have seen changes in their lives as a result of the services. Furthermore, this consultant assured the participants that they would remain anonymous and asked that no staff participated in the consumer focus group discussions.[3] It is thus not surprising that while some of the comments are too general to be used for improvement, some are specific and to the point. In fact, consumer perspectives are enlightening and insightful and should be listened to.

Table 5 shows the general themes from these group discussions:

[3] In one instance, the CAP-DD staff were included with the occurrence of a family member in light of the difficulty of the consumer in expressive speech, and in another instance, the staff stayed on with the concurrence of the consumer for part of the discussion, but left the room when the questions turned to the consumers' feedback about the services.

Table 5. Themes from Consumer Focus Groups

Domain of Questions	Themes
Communication	Consumers already receiving services are informed of their rights and rely on their primary therapist or case manager for service availability. Those with longer tenure in the system also use peers for information and support. However, there is a shared concern that the general public does not have sufficient knowledge about the service array, or the disability system.
Access	Many entered the system years ago. For those have entered since the reform, IPRS referrals came from the LMEs; Medicaid referrals came from a variety of sources. The common concern is that the general public doe not knowing where to go for services. There are also noted communication barriers when the STR system is used by DD consumers.
Services	Consumers felt the services have changed their lives. Service gaps identified include supported housing, supported employment, and intensive outpatient and long-term rehabilitation for substance abuse. The SPMI consumers tend to be found in the psychosocial rehab program with medication management, some in ACT. For DD consumers, more supported living for long-term adult consumers still residing at home or in group homes is needed.
Crisis and Emergency Needs	Consumers first rely on informal support for crisis and emergency; there is acknowledgement that crisis services have become more available. Children and youth consumers need in-home support and respite, whereas adults need a full continuum of crisis and emergency services and early interventions.
Appeals and Experiences with Complaints and Grievances	Only a few consumers in the focus groups have used complaints and grievances; some have taken actions to dismiss a poorly performing provider.
Quality and Service Outcomes	The majority of the consumers have described improvement in their lives as a result of the services, and all of them place a premium value on being treated with dignity and respect by the provider staff.

Alamance-Caswell-Rockingham LME

Three consumers participated in the focus group meeting, including one CFAC member, one consumer studying to be certified as a peer specialist, and one formerly homeless consumer receiving ACT services. All three spoke positively about their experiences at the agency. They rely on their community support and ACT staff to help them in their recovery, even in the case of one participant becoming independent by obtaining a peer specialist certificate. They described an easy, open communication with the provider staff.

Specific comments:

"I called two places for help when I was in jail for having serious problems of wanting to hurt someone. The ACT staff came to me right away, so I chose him. I figure he showed me he cared and that meant a lot to me."

"The staff have helped me get back on my feet."

"We need a job and a place to live."

Albemarle Mental Health Center & Developmental Center & Substance Abuse Services

Two families of consumers served at the agency participated in the interview. Both have received services that helped their family members improve coping skills and maintain community integration. The services have been provided on an outpatient basis: in one case the intensity has reduced as the youth has become better equipped to handle defiant and assaultive tendencies.

Specific comments:

"What parents need is in-home support."

"We can all use parenting class."

The Beacon Center

Seven adult mental health consumers participated in the focus group meeting. They are currently attending psychosocial rehabilitation programs (some five days a week and some three times a week). They described the skills training program they are involved in and their recovery process despite hospitalization at Cherry Hospital. They identified service gaps in education about medication management and supported employment opportunities.

Specific comments:

"I like the staff here because they talk with you, not at you."

"My experience at the state hospital was very unpleasant. I'm glad I'm out of there."

Mental Health Services of Catawba County

Ten consumers (two parents) and a CAP-DD staff (there to interpret for the DD consumer) participated in the focus group meeting. Many of the consumers lived at home, some were in a group home setting, and only one was in a rental apartment. All attend day activities and one consumer is about to complete a high school diploma. Their tenure with the service system varied—some were newly enrolled, some have had a long service history. The parents also receive respite service from the agency.

They all expressed appreciation for the services they have received and the attitude of the staff at the agency. The CAP-DD staff expressed concerns that the hours have been reduced for her client by Value/Option. The parents participating in the discussion identified their primary concern as the life plan for their DD family member.

Specific comments:

"I'm getting better now. The staff treat me like a real person. I like my staff. We can go shopping or have my hair done whenever I want it."

"I've been to other places but they acted as if I wasn't there."

"My husband and I are getting older. We want our son to stay in a home setting, and we worry how it can be maintained."

"We are glad for the respite we get."

"I just moved from another county. I like it here, but I'm making less money in the day program."
"I don't understand how they can cut the hours. People need the services (referring to adult habilitation services)."

Center Point Human Services

Two consumers in the waiting area participated in the interviews, as the originally scheduled consumers of ACT had left the program site. Both consumers were parents with children in mental health outpatient treatment. The information gathered was scanty and not used.

Crossroads Behavioral Health

Two consumers (including one Hispanic consumer) in the facility-based crisis center participated in the interview. Both had arrived less than three days ago from jail and from the local hospital. Both had met the admission criteria in terms of acuity and were now ready to be discharged. They felt the staff at the crisis center helped them deal with the crisis that would have led to psychiatric hospitalization; their current primary concern was follow-up treatment. Neither had a service history with the public system.

Cumberland County Mental Health Center

Nine consumers who receive mental health and substance abuse services participated in the focus group. All the participants have a brief history with the provider, with an average of two and half months. Some had been homeless and one had recently moved from another state, but all seemed to have positive comments about the staff and services. They brought up the issue of Medicaid eligibility.

Specific comments:
"We need special assistance in applying for Medicaid besides going to the local social services agency. I was able to get mine at the local hospital when the social worker helped me complete the application."
"We need more housing options."

"We have no primary care available. When I get sick, I can only go to an emergency room."
"We (individuals with addiction problem) need a stable living situation."

The Durham Center

Seven consumers participated in the focus group meeting at the substance abuse services site. Most of them are in a transitional housing program, some are in women's recovery residence, and all were vocal. They were more than satisfied with the services, they were enthusiastic. Regarding service gaps, they felt more choices in supported housing are needed, especially a stable living situation to assist them in their recovery.

Specific comments:
"I'll give the staff two thumbs up."
"I have tried treatment before, but never stayed. When I first came here, the staff called me by my first name. Man, that convinced me they do care. Later when I relapsed and returned, they still remembered my name."
"They are more confident in me than me."

East Carolina Behavioral Health

Two adult consumers (one primary consumer, one family member) of SA services participated in the focus group; more consumers had expressed a willingness to attend but did not show. The adult consumers have had a long tenure with the agency: one of them has an adult child using a residential recovery services for an addiction problem in another LME region. Both consumers expressed their satisfaction with the provider in terms of keeping them informed of available services, and both have developed a good personal relationship with the management and clinical staff.

Both consumers expressed a need for long-term residential support for individuals with substance abuse problems. One consumer whose adult child had to be admitted to a residential treatment center in another LME area felt such services should have been more readily available across the state.

Eastpointe

Eight consumers participated in the focus group, including three parents of DD consumers, one of whom is on the board of the LME. In addition, a CAP-DD staff was in attendance to explain services received by a DD consumer. The CAP-DD staff stays with the same consumer in all program activities. The tenure with the public system ranges from three to over ten years. There is strong support of the provider for its stability and variety of services provided, from day support to a sheltered workshop. One consumer has an independent apartment, one is in a group home, whereas the rest live with their parents. They all shared positive feedback about the services received, but none expressed a strong interest in moving out of the sheltered workshop setting.

Specific comments:

"The public system needs to develop more supported employment programs."

"The person-centered plan does not work for the DD clients because we as parents end up completing them."

"Too many system reform changes and inconsistent direction from the state."

"Turnover in community support is dreadful. I had to fire a case manager from a program because she never showed up."

Five County Mental Health Authority

Only one consumer wished to be interviewed on-site. This is a new consumer, having completed only two outpatient visits, as referred by DSS. She is being treated for mental health problems and hopes to obtain employment. Recently relocated to the area, she has had no prior service history with the public system. Other than expressing her satisfaction with the services offered, she did not contribute much to the areas of inquiry.

Foothills Area MH/DD/SA Authority

Only one consumer at the provider site was available on the day of the visit. This was a youth receiving community support services. The interview took place with the consent

of the staff and the child. The youth had just been suspended from the school, the second time in a week.

The current community support staff has worked with the youth since September 2007, replacing another community support staff. The staff provides 1:1 supervision during the school hours, five days a week. The youth explained that the community support staff sat next to him in the classroom, and his teacher did not seem to mind. The primary concern as expressed by the child is anger management, for which he is also taking medication. He has been suspended by the school system several times for hitting other children. He lives at home with other younger siblings; according to him, he never hits anyone at home because "they are family."

Specific comments:
"The staff is OK. We get along. He helps me control my anger."
"I would like to get off the medications. They made me dizzy. I also have trouble sleeping (I was up until one o'clock this morning)."
"I'm doing all right in school, I was held back only once. I never hurt anyone."
"I never had any services before. Now I'm getting a staff. I also see a therapist for counseling at this place."

Guilford Center for Behavioral Health and Disability Services

The community support staff had scheduled volunteer consumers to be interviewed, but the consumer focus group did not take place because of "no show."

Johnston County Area MH/DD/SA Authority

Eight consumers of the outpatient and residential substance abuse services participated in the focus group meeting; about half of them are on psychotropic medication. Some are outpatients while others are inpatients at the residential treatment site. They still go to the LME for medication management, but there is an eight-week wait. Not being able to get in touch with their case manager is also a chief concern. They are pleased with the provider's services.

Specific comments:

"When I was hospitalized for detox, the nurse in the hospital seemed to look down on me."

"There is a general lack of understanding of addiction problems."

"We love the staff here. They really care."

Mecklenburg County Area MH/DD/SA Authority

Eleven consumers and families from Mecklenburg participated in the focus group discussions. The consumers ranged from nine to sixteen years old, and were accompanied by their parents or foster care parents. All children in the focus group are attending regular school, but some are in foster care or residential care. Although no clinical files were reviewed, the children collectively seemed to present mild mental health and behavioral management needs. One parent came with her child to the focus group meeting to register her concern that she has had trouble accessing the system. It turned out that she does not have insurance coverage and is not eligible for Medicaid. It is interesting to note that those consumers already enrolled in the services suggested that this parent attend parent-to-parent meetings. The exchange among the parents in this focus group demonstrated the power of mutual help.

The participants felt sufficiently informed about the availability of services in the community and understanding of consumer rights. The parents and youth in the group relied on their immediate therapist for information about service availability. Many of the participating parents are also active in associations (e.g., foster care parents association) and have a broad information base about agency services and community resources.

One parent who had access problem described her own struggle in obtaining services for her child in school and with a primary care physician, to no avail. "I was referred repeatedly to parenting class, but I need treatment for my son." She has been turned away by all the providers, including the provider being visited on this date, for lack of insurance coverage or ability to pay.

Others in the group seemed to have less difficulty accessing services and thought that the process for them was relatively easy to navigate. Many have their services paid for by social services, or by the LME (for residential care).

Specific comments.

"If I can have in-home support or occasional relief for child caring, I could have managed my child by myself."

One parent had gone through the process to change community support staff, "I fired my community support person because she never visited me." The rest were aware of their right to appeal but had never used it.

Onslow Carteret Behavioral Health Services

Five consumers with mental health and substance abuse service needs participated in the focus group meeting: all of them have entered the service system within the last two years and are in supervised apartment provided by the agency. They also receive case management services, medication management, and counseling services.

Their entry came primarily from community referrals (other service system, crisis services) and one was self-referred. Their relatively short tenure with the agency is due to the fact that the agency was only created two years ago. Only two of them have Medicaid eligibility, and one is in the process of applying with the assistance of his case manager. They are concerned about the high turnover of their case managers.

Specific comments:

"My needs are the same, even though I don't have Medicaid. My case manager told me until I get my Medicaid, my hours cannot be increased."

"I've had four case managers in a year already."

"The apartment situation is a blessing, and saved me from becoming homeless.But the maintenance is atrocious."

"Our major need is employment."

"If I'm in crisis, I will call my case manager. But for other needs, I have friends in the community."

Orange-Person-Chatham MH/DD/SA Authority

Three consumers receiving supported employment, supported housing, and medication management participated in the focus group meeting. They had been referred by other service providers, and have seen a steady improvement in their lives. All meet the criteria for targeted populations, and two are eligible for Medicaid. One is affected by the recent closing of a community provider that had provided medication management, but the closing was note considered a loss because of dissatisfaction with the psychiatric services there. Two consumers that receive their medication management from the UNC Step-clinic are satisfied with their services. It is worth noting that all consumers make use of family and social support, as well as community resources.

Specific comments:

"This agency has turned my life around. I was suffering from mental illness with low self-esteem. Now two years later, I'm having my own apartment and holding down a job. This place is like a family to me."

"I did not like the psychiatrist I had; he never spent time listening to me, and he never told me the truth."

"I like the psychiatric residents at the Step-clinic. They are very personable."

Pathways MH/DD/SA

The consumer focus group was held with adult mental health consumers in recovery services as a substitute for another provider that primarily served children and youth and could not obtain clearance for the children and youth to be interviewed in time for the visit. Five adult consumers participated in the focus group discussion: two of them have had long tenure (ten years or more). All five consumers confirmed their understanding of consumer rights and provider information. During the divestiture the two consumers with long tenure with the service system were able to follow their original therapist to the new provider location.

It is evident that because of prior involvement with the public MH/DD/SAS system, two consumers did not require new access, whereas the newer consumers (those who entered the system within the last three years) had to learn how to access services. None reported any difficulty in access, and all attributed their lack of barriers to the good counsel of their friends in the community. The LME was able to refer them in a timely manner to appropriate mental health services. Several members have experienced relapse during their tenure with the program, including hospitalization at the local hospital and state psychiatric center. They had unfavorable experiences at the state psychiatric hospital, feeling a loss of freedom of movement and lack of community contact. Their experiences at the local acute care unit were better and they felt good about being close to their family and friends. One consumer who did not attend the focus group (although scheduled to attend) had recently suffered a relapse. The group spent sometime discussing the reason for the relapse: WRAP (Wellness Recovery Action Plan) had not been followed. All of the participants in the focus group emphasized the need to have someone to call in crisis, and many expressed a reluctance to burden their own family members. They are comfortable calling their therapist for help, and many have.

Specific comments:

The consumers currently participated in the WRAP (Wellness Recovery Action Plan) group. All spoke positively about the experience.

"I have learned how to live."

"I have been able to make friends."

"We support one another in the group."

Piedmont Behavioral Health

Eight adult consumers participated in the focus group, including one through a phone interview (this consumer has experienced barriers to access on behalf of a family member with addiction service needs). Three participants were also CFAC members. All disabilities were represented in the consumer group. Although the participants were familiar with consumer rights and service availabilities, all felt that the general public still

lack basic knowledge about the MHDDSAS system. One participant is acting as an advocate to obtain mental health services for an adult friend and has found a long waiting list and barriers to completing the lengthy paperwork requirements. Turnover at the therapist level has also made it difficult for consumers already enrolled—developing a relationship with a new therapist takes time.

Specific comments:
"The providers do not let people know they have services available."
"Ten minutes of conversation with my psychiatrist did not help me. I never learned about drug side effect or interaction."
"It's demeaning not to be greeted by your name. Each time I check in, the receptionist asks for my name, even when I've been coming here a long time."
"The system does not know how to treat married couples with mental health problems"
"When we call the hotline, we want to talk to a person, not a recording voice."

One consumer called the director to complain about access problems and was transferred to the group moderator. The concern is related to the requirement that a full PCP must be completed before services can be authorized, and after two visits the consumer's family member with addiction needs simply did not return. With some follow-up intervention by the agency, a faith-based organization accepted the family member into treatment.

Sandhills Center for MH/DD/SA Services

Ten consumers participated in the focus group meeting. The majority of them have severe and persistent mental illness and were open about their own diagnosis. All of them attend the psychosocial rehab program at two different locations. The programs are designed to offer different levels of skills training.

What is striking about this group is that many have been in the public system for a long period of time, whereas some entered the system within the last three years. Together they can be considered the target population as defined in the state plan. They feel supported by the staff and seem to have developed a close working relationship with the

staff in the program. However, they all expressed an unfilled goal of achieving the next level of independence, especially supported housing and employment. Some of them live in group homes, others in independent apartments.

Specific comments:

"My goal is to go back home to my own children."

"My doctor told me I can never hold on to a job, so I quit trying."

"If I can recuperate, I'd be so blessed."

"I'm trying to finish a community college degree, and this is my third try, so that I can find a good office job."

Smoky Mountain Center

Eight consumers (including two parents) participated in the focus group discussions. They represent consumers with mental health, MH/DD, and DD service needs. The DD consumers expressed high satisfaction with their life circumstances, and those with dual diagnosis are receiving psychiatric and counseling services at another provider agency. The parents of a youth that has experienced repeated hospitalizations had the most to say about "cracks" in the service system. They attended the meeting on behalf of their family member who was hospitalized at a state hospital.

Specific comments:

"The sheriffs took down our son during the transport and caused injuries. I complained to the sheriff's department and received no response. I don't think the officer was malicious, he did not know how to handle people with mental illness."

"We complained to the mental health center staff (note: LME) and we have had good help there. Our concern is for a step-down service when our son is ready for discharge. There is nothing available in the community that would offer structure and treatment."

"I was just promoted to a staff position. I'm happy with my life. I go to work every day and punch in at 8 in the morning, and I have a girl friend."

Southeastern Center for MH/DD/SA Services

Eight consumers that have addiction service needs participated in the focus group meeting, including two referrals from the criminal justice system. The tenure of their service history ranges from a few months to more than ten years.

Overall, they have found motivation and are engaged in treatment and recovery. Those with longer service history and have graduated from intensive outpatient to monthly visits seem to offer hope and inspiration for those who have entered the system recently. Currently none are eligible for Medicaid and employment is an issue.

Specific comments:

"I've been completely turned around. I can't say enough about this place. After failed tries at staying clean, I've had the longer period staying off drugs."

"I came here to keep clean and get my life on track, but you have to want to do it."

"I've tried several times before to keep clean and failed, but I've finally succeeded the third time. It's the good staff here that helped me."

"We need help with employment, and we need a place to live."

"I love my counselor, but I wish I had more psychiatrist time. I need mental health services as well as services for my addiction problem."

"The staff here seem to carry a heavy load; there is such a great need. The waiting room is usually full."

"We need more assistance in finding employment, especially for having an arrest record."

"My family is paying for the cost of the services now, and it will take me a long time to pay off my fees here."

Southeastern Regional MH/DD/SA Services

Two consumers receiving psychosocial rehab services participated in the focus group. At their request, the interviews were conducted one-on-one for each. Both consumers have had a long service history with the public system, dating back to the late 1980s and early 1990s, and have had psychiatric hospitalizations in their past.

What seemed striking is the lack of information about the current mental health system in their community. They both assumed the former area program (the Mental Health Center) had closed and nothing else was available, when in fact the same psychosocial rehab program has had a smooth transition from the former area program to the current provider and there are other mental health providers in place. It demonstrates that consumers often identify with a physical location and personnel they are familiar with.

They are pleased with the services they receive, and their perspective is that this is the only stable thing in their lives.

Specific comments:

"I have a case manager assigned (note: from community support) but I have only seen her a couple of times, and she did not seem to want to talk me. She gives me transportation to go places."

"I used to be able to talk to someone, but other than the Club House members, I have no one to talk to. The psychiatrist never spends time with me."

"The staff here are very caring. If I don't show up, I get a call from them. The other week I was feeling depressed and they talked me into coming. I'm back to normal now."

Wake County Human Services

Six consumers with mental health, substance abuse and developmental disabilities needs participated in the focus group meeting. They represented different stages of recovery and habilitation. Some will remain in a group home setting while attending a sheltered workshop, whereas others are moving from supported employment to independent employment. One consumer with repeated hospitalizations is finally stabilized in the ACT program. They all provided positive feedback about the agency and services they have received.

Specific comments:

"I have been in and out of Dix for years, but now that I have an ACT team staff assigned, I can call him to avoid a breakdown. I called him on a Saturday the other day and he

immediately came to talk to you. This time, I recovered and did not have to go to emergency room or the state hospital. I can't say enough about the difference it has made in my life."

"The staff here treat you with dignity and respect. Never once did I feel unappreciated."

"There is one thing I need that I'm not getting—supported housing for people with addiction problem. I'm still looking."

"I've learned to budget and to plan ahead. Even though I'm living in a group home, I can be more independent."

Western Highlands Network

Four consumers participated in the discussion. They all requested individual interviews. They were attending a Fountain House clubhouse program in addition to receiving psychiatric services (medication management, therapy) and community support from the same agency. They were engaged in various activities on the day of the visit and welcomed the opportunity to speak to a visitor.

Specific comments:

"The staff here care. They are for real. I've been coming here for six years. You can't fool me for that long. I lost all my friends and family when I went to the state hospital. Now I'm making friends here."

"I suffer from flashbacks from abuses in a military training camp. I like my therapist in another program, but I wish they had group sessions for people with similar problems."

"I'm learning structure here."

V. Provider Feedback

The provider feedback, as given by the participants, represents perspectives of management and staff. Participants for each focus group include management, clinical and business staff, and online staff routinely interacting with the LME management and staff. Thus the focus groups offer a glimpse of the provider experiences at multiple organizational levels. The quality of the interaction with the LMEs also goes below the LME leadership; it is about LME staff assigned to different functions and the LME's overall provider relations.

Because there are more providers in the sample contracting with multiple LMEs than with a single LME, the feedback described below represents more than one provider's perspective. Some patterns of response are noted.

There is a tendency for providers that deal with only one LME to be positive about the experience, whereas providers involved with multiple LMEs tend to be frustrated by the inconsistencies in LME practices in areas that matter to the providers, from endorsement to authorization, to payment, and to provider monitoring.

Second, substance abuse providers have the most difficulty in dealing with multiple LMEs. This is owing to the lack of infrastructure at the provider level to meet multiple IT requirements, compounded by the fact that, given the scarcity of substance abuse services, many referrals came from outside the immediate LME area. The high demand and insufficient supply created a waiting list for consumers: some of them could not be served after the denial of payment (Medicaid and IPRS). For providers that are mission driven and committed to serving consumers despite denial or no-payment, this represents a serious business hazard.

Finally, one phenomenon that cannot be interpreted at this point is the inconsistent treatment of providers by LMEs, or at least the provider's perception of inconsistent treatment by LMEs. The same LME might be responsive toward one provider but not to

another. Hence the data presented in the feedback shows some inconsistency. It is not uncommon for the same LME to be perceived to be “good in doing business” by one provider and “bad in doing business” by another.

Of special note is the role Value/Option plays in the provider feedback. Though the focus of this review is on LMEs, the interaction between providers and Value/Option is considered problematic by all but two providers in the sample. The areas of concern include:

- Value/Option does not have a web-based authorization system (a pilot site is being launched), and providers have to fax lengthy person-centered plans.
- Providers do not receive authorization in time: the delay can be anywhere between several weeks to months. Providers claimed some of the faxed materials were lost and had to be refaxed, and notification to providers was mislaid by being sent to the wrong address.
- Value/Option staff do not return phone calls and are not coordinating among themselves; the providers often had to repeat the authorization process with a different staff.

Table 6 Themes from the Provider Focus Groups.

Domain of Questions	Themes
Communication	Good and timely communication from the LMEs, and in some cases LMEs had provided synthesized analysis despite some duplications for providers with multiple LME contracts. The concerns are that the LMEs interpret rules and regulations differently and tend to add requirements beyond the state standards, thus making standardization difficult and costly to the providers.
Access	Most providers prefer to take Medicaid referrals for improved benefit package and open enrollment process; some expressed concerns about the lengthy access and payment process for taking in IPRS consumers.
Services	Providers tend to identify service gaps based on their own consumer base, and some expressed concerns about LME giving services to preferred providers. Whether or not the provider offers single-service or core services, they have pursued community support funding.
Endorsement and contracting	Major concerns about duplications in endorsement when a provider serves multiple LMEs; contracting has become more uniform though the provider needs to go through the contracting process whether the consumer base is small or large.
Utilization review and utilization management	Major concerns about authorization from Value-Options in terms of delays and denials, and cumbersome process for seeking authorization without web-based support. Varied concerns about LME process for authorization of IPRS referrals and claims payments; some LMEs are performing better than others
Appeals	The majority have used the mechanism, but are not satisfied with the time-consuming process and lack of closure for Medicaid funded services. For LME-specific issues, the chief concern is the degree of responsiveness from LME staff, some respond in a timely manner while others do not.
Provider monitoring	Major concerns about multiple entities involved in monitoring without coordination at the state and local levels; concerns that monitoring is focused on compliance with administrative procedures, not enough on service outcomes.

Alamance-Caswell-Rockingham LME

Five staff participated in the discussion, including clinical staff responsible for delivering psychosocial rehabilitation, ACT, and mobile crisis team. During the meeting the crisis staff took several calls and left the group to deal with emergencies, but returned toward the end. This provider serves three LME areas. Communication with the LME is good; there are frequent provider meetings and regular communication about state guidelines.

Although there is a steady flow of referrals from STR for services at the agency, there are vacancies with the ACT slots. The participants felt this is owing to community support staff not wanting to refer to ACT. One staff felt the concept of "clinical home" should be revisited, for placing it with the community support program has not enhanced consumer access to other services. Authorization takes time. Slow payment for IPRS reimbursements discourages the provider from taking IPRS referrals. The experience with Value/Option is worse; resolving pending authorizations can take months.

Specific comments:

"When we accept referrals from the LME, we don't get paid on time at all. As if we are forgotten."

"We have many unpaid claims by the LME."

"The LME staff tell us what goals we should set for consumers, and how to do treatment. I thought that was our job as providers."

Albemarle Mental Health Center & Developmental Center & Substance Abuse Services

Three staff participated in the focus group meeting. They have been providing services for four years, and none of the consumers served here are funded by IPRS; all receive Medicaid funding. The reason given is that the provider could not deal with the LME who keeps an arms-length relationship with all providers, holds provider meetings on a quarterly basis, and does not communicate changes in state rules to the providers. In

addition, the LME continues to be a provider: in their provider endorsement process the provider was made to feel that there is no support for the success of the endorsement.

Yet this distant role assumed by the LME has not helped its provider monitoring, as many new community support providers have entered the area. According to this provider, community support providers with questionable practices (no qualified personnel and abuse of community support hours) are still in operation, and none have lost their endorsement status pursuant to the full endorsement review. The provider also believes that the STR function, as contracted out by the LME to a crisis services tends to favor referrals from its own consumer base, and on occasion when the provider uses the services there has been little follow-up communication about the services at the crisis center.

Positive feedback about the LME came from the provider's praise of two LME staff who have shown a willingness to collaborate with the provider community.

Specific comments:
"It's hard to see them as our management entity when it is also a large provider. There is no fire wall."
"This is a tight community, and unless you are friends with the LME staff, you don't get any referral of services."
"We have purposely avoided using community support for consumers who need intensive in-home interventions, but our request to be endorsed as an intensive in-home provider has been delayed at the LME level."
"Many providers who provide community support spend enormous time in school with the youth. We tend to provide community support outside the school setting, involving the families because parenting is a key concern."
"We did not realize how LMEs behave differently until we started providing services to another LME. We are so pleased with the training, technical assistance, and communication we receive from this other LME than from our own LME."

Comments from contracted providers in other LME regions:
"Albemarle LME is standoffish; they ignore us because they still provide services."
"The only service the LME has divested is outpatient services because it's money-losing business for them."

The Beacon Center

Eight staff participated in the focus group meeting. The agency was established in 1996 first as a home-care agency, then later expanded to provider mental health and developmental disabilities services. Many of the staff came from the former area programs. The staff were critical of the LME operations, citing lack of responsiveness and using a finance officer to deny authorization of IPRS without providing a rationale. The provider also offers services to two other LMEs.

Specific comments:
"Infrastructure cost to the provider is tremendous when dealing with different process and processes from different LMEs in terms of utilization management, payment."
"We don't have any problems with Value/Option in getting timely authorization."

Comments from contracted providers from other LMEs:
"Beacon Center is too slow in paying their IPRS claims."

Mental Health Services of Catawba County

Six staff participated in the focus group meeting. This is a comprehensive DD provider with more than ten years of operation. It has expanded its services to eight LME areas. It serves DD consumers with dual diagnosis, but the provider considers itself a primary DD provider.

Because of the history of the top management in the public system, the discussion began with the provider's view of the reform, which is mostly negative. The provider considered the 1960s to be the good old days of service delivery.

In terms of dealing with eight LMEs, the chief concern is inconsistent interpretation of state rules, plus adding new LME-specific requirements without enough advance notice. Another area of concern is in the endorsement process—even if the provider has already received endorsement already from the local LME, other LMEs continue to do a full endorsement review, and duplications of meeting the same requirements taxed the provider's resources. Authorization for IPRS as well as payment for IPRS services is also inconsistently carried out by individual LMEs.

Specific comments:

"Sometimes the state sends out clarification of rules based on feedback, and the LMEs ended up giving us 'clarification of the clarification.' Why can't the rule making be limited to a couple of times per year?"

"The preoccupation of the LMEs is survival now, and not about services to consumers."

"Some LMEs have closed provider network; we were told not to apply for IPRS funding in one LME even though we have had a strong presence there."

"We get along with the LME here. We can call or email and get an answer. Some LMEs never return your calls."

Center Point Human Services

The provider offers a wide array of children and adult services in seven LME areas, and has undergone major growth since 2003. Multiple LMEs share duplicated information, but the provider did not see it as a problem. The provider is frustrated with having to deal with seven different authorization systems for IPRS-funded services from seven LMEs.

Specific comments:

"When no providers come to the plate to accept the referral from the LME, some brokering should be performed by LME."

"Community support program does not refer consumers to other services when such needs exit."

Crossroads Behavioral Health

Three staff participated in the focus group meeting. The provider offers comprehensive services in thirteen LMEs. They praised the level of communication with the LME and in particular the involvement of the consumer relations representative at the LME for his interest and advocacy.

The providers also considered the LME in the upper tier in processing authorization and payment for IPRS-funded services. The LME has consistently supported the current crisis service even when there is a fiscal shortfall; they were less complimentary of other LMEs with whom they have a contractual relationship for two reasons: delayed authorization and delayed payments. They have difficulty dealing with different systems from all thirteen LMEs.

Specific comments:

"Overall, there is still a deep learning curve for LMEs to let go of a clinic-based model and embrace community-based services."

"The provider's perception is more related to the individuals they work with than the leadership, so even when the LME director is good to work with, the staff responsible for provider relations can change the nature of the relationship."

Cumberland County Mental Health Center

Six staff participated in the focus group meeting. The provider has been in existence since 1987 and currently covers two LME areas. It is striking to see that the entire management and clinical team are African American. The participants shared their complex relationship with the LME in that the partnership has been rocky, and they have felt slighted for not receiving referrals for substance abuse services despite the fact that they have the largest number of licensed SA professionals. They allowed that they are fully endorsed, but that the last endorsement required several plans of correction.

Specific comments:

"Our LME is proactive in providing timely to all providers. But the referrals tend to go to providers that have personal relationship with the LME staff. When we complain, we might get a few more."
"Because we don't get enough referrals for substance abuse services, we have to absorb the cost."
"Our LME has prepared us for the transformation, but we are like a married couple, with good days and bad days. We have a love and hate relationship, but there is enough mutual respect to keep going."
"The LME endorsement review showed their lack of understanding of the rules; we had to argue every step of the way."

Other comments from contracted providers outside the LME area:
"Cumberland LME is slow in paying us. We are still owed $10,000 from June 2007. For a small agency, we can't survive like this."
"We can't wait for Value/Option to get a web-based authorization system developed. They keep losing the documents we faxed them. Right now the turnaround time is sixty to ninety days."

The Durham Center

Nine staff participated in the focus group meeting at this provider of substance abuse services with contractual relationships with five LME regions. The provider also operates access for the LME. The participants felt that there is good partnership with the LME that offers technical assistance and training to the providers and has designed a "best practice liaison" with the provider to nurture the quality of services provided. The weekly newsletter from the LME is also considered a good communication mechanism with the provider community. The provider does not have any problems with authorization and payment of IPRS funded-services from the LME.

Specific concerns:
"Though it is well-intentioned, sometimes we feel the Durham Center staff have a tendency to micromanage."

"The patterns of endorsement from LMEs are so varied that we are under severe strain."
"The PCP documentation is still not user friendly, especially for consumers with substance abuse problems."
"Can't we simplify paper work requirements?"

Other contracted providers outside the LME:
"The endorsement process at Durham is too cumbersome and lengthy, just to serve a few consumers. We are already fully endorsed by our own LME and there is no recognition of our standing. We had to go through a full endorsement process with Durham Center."
"The Durham Center's monitoring is too detailed with a focus on record review."

East Carolina Behavioral Health

The provider was incorporated in 2003, on the heels of the mental health reform act. It was established by a clinical management team that had worked with the area program and brought on board close to fifty former area employees. To date, thirty-five or so remain: those who had left originally came primarily from another area program that had problem adjusting to the different expectations in a private not-for-profit agency. The provider experienced early growing pains but has on its own acquired needed expertise in business functions.

The provider participates in regular provider meetings at the LME, receives weekly correspondence and notification of new state rules. In addition, the LME has conducted training of person-centered planning. Authorization by the LME is relatively trouble-free; this difference is explained as a result of the LME staff responsible for UR/UM, "They used a clinician for the role, which is quite assuring for us."

Specific comments:
The agency receives IPRS referrals from the LMEs and Medicaid referrals from multiple sources. One problem noted was the referrals from community support providers.

"They usually refer consumers with severe symptoms for psychiatric or nursing services while retaining the community support function even when we think a different level of care is required. Such referrals have created some clinical liability for us."

Comments from contracted provider in another LME area:
"We have developed a new ACT for East Carolina and yet there are no referrals from the LME."
"There are serious gaps in intensive outpatient services for consumers with addiction problems."
"Too much paper requirements that did not seem to make much sense. We need to move into electronic data exchange."
"East Carolina just changed the rule for on-call system that requires a psychiatrist to be on call during the weekend. This is not possible for us to meet."

Problem with Value/Option's authorization and denials. "Their denials are not based on clinical criteria, and we do not get notification in time, nor are they responsive in returning phone calls."

Eastpointe

Four staff participated in the focus group meeting from a DD provider. The provider takes referrals primarily from Eastpointe but has on occasion taken referrals from other LMEs. It is evident that the long-term relationship between the CEO of the provider and the LME director has led to a smooth working relationship between the two that filtered down to the staff level. Communication with the LME is good, and the agency is having less difficulty with Value/Option than other providers. It also helps that 65 percent of the agency's revenue comes from sheltered workshop contracts.

Specific service gaps identified: supported living and transition out of group home and supervised living situations: transportation in the rural region; respite for families; and mental health counseling for DD consumers, especially those with coexisting disorders.

The provider did not think monetary incentive is enough to attract more professionals into the system: “It takes certain types of people to go into the field.”

Comments from contracted providers in other LME regions :
“To get one referral from Eastpointe, we had to complete a brand new set of forms.”
“Authorization from Eastpointe takes forty-eight to seventy-two hours and is sent via email.”

Five County Mental Health Authority

Four staff participated in the focus group meeting at this child and adult mental health and substance abuse agency established in 2006 to serve primarily the LME area. The management staff had worked in different LMEs and saw a new market in the five-county area. They have quickly expanded since and are in the process of developing a new site in the region.

They are pleased with their relationship with the LME: referrals are steady and payment is timely for IRPS-funded services, but not so with the Value/Option’ process.

Specific comments:
“The attitude of our LME is that let’s make the hard process easy for our providers.”
“The LME STR does follow-up to make sure clients are enrolled. The LME has our calendar and can schedule appointments for consumers.”
“The LME provides us with technical assistance during our start-up.”

Foothills Area MH/DD/SA Authority

Four staff participated in the focus group meeting. This is a comprehensive service provider for children and adults with MH/DD/SAS needs, and has returned to a provider status (after a hiatus) in 2003 on the heels of the mental health reform. It serves fourteen LME areas.

Because of the long reach of the service network, this provider is vocal about the cost to doing business from duplications in endorsement and monitoring, and how inconsistent practices at the LME level have affected their ability to stay in compliance. In addition, they voiced concerns about individual LMEs adding requirements that are not part of the state guidelines.

Specific comments:

"There is no real standardization if the LMEs are allowed to add new requirements, and if they all interpret rules differently."

"Depending on whom you speak to at the LME level, you get different answers about a particular requirement."

"I think it's the mindset of the LME staff that does not trust providers to do what they were unable to do when they were providers."

"It's an issue of basic skills and competency. LMEs were thrown into doing something they don't know how to do."

"It would make our life easier if the state requires that endorsement and monitoring be done in the LME area where the corporate office resides, and have other LMEs accept the deemed status."

Comments from contracted providers in other LME areas:

"Foothills is the worst in paying the claims, and in authorizing services. They owe us at any given time $100,000."

Guilford Center for Behavioral Health and Disability Services

Seven staff participated in the focus group meeting at this comprehensive service provider that serves primarily the Guilford LME and another LME (for limited mental health services). The participants expressed satisfaction with the communication and provider relations with the LME. For authorization LME, they use CareLink to provide web-based support. However, IPRS payment is often delayed by six to eight weeks because it is generally tied up in the county accounting system.

Specific comments:
"IPRS authorization takes about forty-eight hours, but Medicaid authorization takes anywhere from a week to a month, and we had to fax documents to Value/Option."
"There is a need to standardize IT requirements between Medicaid and state-funded services."

Comments from contracted provider from another LME:
"Guilford staff wants to tell you how do treatment; they are too overreaching and controlling."

Johnston County Area MH/DD/SA Authority

Five staff participated in the provider focus group meeting. The provider is an established (since 1974) substance abuse service provider that offers residential treatment and outpatient services. Though it serves primarily Johnston County, it also accepts referrals for residential services from five other LMEs.

While the provider is pleased with the authorization and utilization review by the LME (both timely), it is less successful in getting authorization and payment from other LMEs covered. The agency does not have the infrastructure to develop an IT system that can interface with different requirements from different LMEs. As it is, the provider is not only dealing with different information requirements, the protocols for authorization thresholds also differ.

Increasing paperwork requirements for obtaining service authorization has also drained the agency resources, but more importantly, when authorization was "pending" or "denied" months later, the agency had already served the consumer without pay. The provider did not feel they could discharge the consumer at that point, but "there are lots of other providers that simply send the consumers into the streets."

The provider has serious concerns about dealing with Value/Option:
"They kept sending letters regarding authorization to the wrong address."

"The V/O staff lose PCPs we faxed and sometimes we had to refax several times to different people there."

Mecklenburg County Area MH/DD/SA Authority

The provider chosen for the Mecklenburg County is a comprehensive provider of children's services with a full-service continuum and over three decades of service history in the state. The same provider also serves eleven other LME areas. The participants consider their working relationship with Mecklenburg LME to be excellent. The LME has established ongoing provider relations and is attentive to inquiries from the provider: "There is a sense of a real partnership." With an open-door policy, the provider receives referrals from other sources, especially other children's service systems. They have also received service requests from other LMEs for residential/out-of-home placements.

The participants expressed concerns about the person-centered plan as a document. The format is not user-friendly, considering the fact that they have to fax the entire plan to Value/Option and LME for authorization of Medicaid-enhanced services and services funded by IPRS.

The participants suggested that having national accreditation should afford them a "deemed status," but the endorsement process and procedures do not make any distinction between accredited and nonaccredited providers.

Another concern they have is that each of the LMEs they deal with has a different set of process and procedures, even those LMEs that use limited services still insist on a full review. One LME's endorsement is not recognized by the peer LMEs. The provider is complimentary about the LME's quality monitoring: "This is the only LME that actually follows up on our report by asking intelligent questions."

Onslow Carteret Behavioral Health Services

Five staff participated in the focus group meeting. The agency entered the provider network two years ago and quickly expanded their services. However, there is no plan to branch out to another county or LME. They have continued to take non-Medicaid consumers (40 percent of their consumers are funded with IPRS), but are in the appeal process for paying back community-support funds.

The provider has something positive to say about individual staff from the LME, particularly the QA staff and IT staff. However, the relationship with the rest of the LME leadership and staff has been rocky from the beginning. They are concerned about LME's delayed IPRS authorization and payment and arbitrary change of service dates; the agency has unpaid IPRS claims dating back to January 2007.

Specific comments:

"The LME has asked a private crisis provider to handle off-hour STR duties, and the same provider also offers community support. It's not a coincidence that most of the admissions to the crisis services came from their community support staff."

"The LME staff responsible for IPRS authorization does not even review it until ten days after the submission. The service management department at the LME is inconsistent in their authorization practice."

"You get the feeling that the LME would like the providers to fail, so they can return to their former provider status."

Orange-Person-Chatham MH/DD/SA Authority

Five staff participated in the focus group meeting. The agency has been in operation since 1974 and receives only IPRS funding. However, 100 percent of the consumers served by the agency are considered targeted population (SPMI), and the provider is frustrated with the long delays in getting them eligible for Medicaid and SSI. Only 30 percent of the consumers have succeeded in getting Medicaid eligibility.

The lack of Medicaid eligibility leads to a reliance on state funds and creates barriers to accessing other community services, especially psychiatric services. They have also had difficulty with discharged consumers from state psychiatric hospitals owing to the fact that the short turnaround of stay at the state hospitals does not permit planned discharge; consumers discharged from the state hospitals do not have their Medicaid eligibility assured.

They have worked well with the local LME and have been able to negotiate authorization thresholds for services; however, the payment remains a concern. They do not receive timely payment and need to relay on other income sources (funding from other public systems) in order to meet payroll.

Specific comments:
"It seems that the state hospitals are left out of the reform. They need to be involved."
"We need more psychiatric services, not necessarily more psychiatrists."
"Service gaps are in nonhospital crisis services, substance abuse treatment services, and more supported employment funding."

Comments from contracted providers in other LME regions:
"Because OPC became LME belatedly, they have lots of catching up to do. The staff are supportive and try very hard."
"They recently asked Five County LME to help them with billing, so perhaps things will improve."

Pathways MH/DD/SA

The provider focus group was comprised of management and clinical staff of a comprehensive children and youth service agency, with a sizable number of management and clinical staff having prior work experience in the former area program. The participants felt communication with the LME has been excellent. In addition to the typical mechanisms of email, webpage news, and provider meetings, the CEO of the agency is also a member of a regional provider association. In fact, four out of five staff

came from the former area program. The association routinely meets to discuss common concerns, attended by a representative from the LME.

The agency receives referrals from the STR unit at the LME; however, they expressed concerns about the small number of Medicaid referrals. Because this is one of the few agencies that accepts IPRS-funded consumers, the agency gets a large share while other private providers tend to favor Medicaid referrals for their more generous benefits. That said, the agency's community-support revenue is 65 percent of its total income.

The agency has worked out a 1/12 month payment schedule with the LME for IPRS payments, thus beyond initial authorization there is no delay in getting reimbursed for services. The agency reconciles the account with the LME after services have been rendered and paid for.

Some serious concerns were expressed regarding authorization for Medicaid enhanced-services by Value/Option. Authorization is often delayed and the use of regular mail was perceived to be inefficient for notification to providers. A typical authorization took ten days to be turned around, and recent denials have been questionable according to the clinical management: "It seems that they were denying the authorization without any good rationale, and it was difficult to have a conversation about their denial when the staff did not return phone calls."

<u>Comments from contracted providers in other LME areas</u>:
Another provider outside the region with contract with Pathways has a different view about the 1/12 payment system: "We don't like it; we prefer to be paid based on claims, because we never knew exactly which consumers Pathways had approved for reimbursement, and reconciliation is difficult." "We usually wait a long time to be reimbursed by Pathways."
"Pathways is getting better in paying the claims."
"Pathways seems to favor its own providers. We were recently closed out of it."

Piedmont Behavioral Health

The agency provides multipurpose, comprehensive services to children and adults and was established as a spin-off from the former area program. The staff have positive feedback about their partnership with the LME and the improved business functions at the LME level, but are critical of the heavy burden of paper work requirements by the state. Person-centered planning documents and NCTOPS for the target population are considered unwieldy and wasteful of resources. It is worth noting that a psychiatrist was included in the focus group by video conference. The provider relations function at the LME level is considered a key strength. The provider felt included not merely in receiving communication about state guidelines and rules and changes in the delivery system, but also in planning, such as IT planning and development of a LME-wide QI system. As a result, the provider felt they had sufficient involvement as a "partner" with the LME.

The psychiatrist who participated in the focus group meeting described the low quality of community support staff he interacted with:

"I cannot deal with paraprofessionals that can't give me an intelligent picture of the clinical condition of the patient. It's unsatisfying to be used to dispense medication only; a psychiatrist needs to be wrapped around by training professionals as part of a team."

"The public system would go a long way to develop regional core services agencies. Psychiatrists like myself would want to work in such a place."

The LME authorization and approval for IPRS payment are performed electronically, but the provider still uses a paper system with Value/Option.

"It's a general problem dealing with Value Options; you never know if an authorization or denial is issued because there is only paper notification and the letter is often sent to the wrong address. Sometimes we have to refax the same PCP documents because the VO staff had misplaced them."

<u>Comments from contracted providers in other LME areas</u>:

"Piedmont pays the claims on time."

"Piedmont may have flexible funding because of the waiver, but they have also created additional process and procedures that seem to overregulate what we do."

Sandhills Center for MH/DD/SA Services

Seven staff participated in the focus group meeting. The provider has conducted business in the state for decades and serves twenty LMEs, including this LME. The participants worked in various aspects of the service delivery, from supported employment, to psychosocial rehabilitation, to peer counseling. The management staff participated in discussion about billing and reimbursement. Overall, their primary concern seemed to focus on the inconsistency of business practices among LMEs, rather than any specific problems with Sandhills.

Specific comments:

"Sandhills intervenes when we experience problems with accessing other services. We need a broker like that."

"Our psychosocial rehab program used to get steady referrals but after March 2006, new community support providers did not refer clients to us. We complained to the LME and they intervened each time we brought it to their attention, but the general trend is not positive. We still get very few referrals from the community support providers."

"One of the community support providers told us the reason they do not refer is because the service is their 'bread and butter' that they don't want to share."

"We see service gaps in supported housing, parenting training, and services to high-risk children."

Smoky Mountain Center

Seven staff participated in the focus group meeting. This provider provides services to a multiple service system, and the portion from MH/DD/SAS constitutes only 2 percent of their total revenue. The provider has been in existence for over thirty years and has enjoyed steady growth over the years; it is also the third-largest employer for the county.

They are very happy with the LME, seeing it as having strong leadership and good practices. The STR has some barriers for DD consumers, one of them complained to the provider about not being able to access services because the consumer could not answer questions required to complete the STR form.

Specific comments:
"We do not take IPRS referrals, and are in a position to talk about the LME's authorization process. But the one with Value/Option is a nightmare."
"We see lack of counseling services to DD consumers as a major service gap. We also need more psychiatrists for the area."

Comments from contracted providers from other LME areas:
"Smoky used to have problem with paying claims, now with a new system they are improving."

Southeastern Center for MH/DD/SA Services

Five staff participated in the focus group meeting. The agency provides a wide array of substance abuse services and was recently awarded a state grant to develop regional capacity. The agency has had more than three decades of experience as a service provider.

The relationship with the LME has been positive and of long standing. However, there are ongoing issues related to cumbersome billing and inability to resolve uniform cost reporting vs nonuniform cost reporting for contracted services, i.e., after-hour STR for the LME, that has plagued the agency for three years. Having to deal with multiple LMEs (this will be expanded once regional capacity is developed) also poses a burden of adaptation to different IT requirements, utilization review protocols, and payment systems. The provider has little positive experience to report about Value/Option.

Specific comments:
"Dealing with Value/Option is more than anyone should bear. We are taking up valuable clinical time to chase after faxed materials, changes in authorization protocols, and poor

communication. Not having electronic data exchange has made doing business difficult with them."

"Sometimes the state guidelines are so unclear that repeated clarifications are necessary. This creates not only confusion for the LMEs, but for the providers as well."

"The paperwork burden has taken us away from clinical care."

"We do not deny services even when authorization is delayed, which hurts our business."

"The LME performs monitoring on site and interviews consumers as part of the process."

"We have serious gaps in qualified workforce in rural areas, especially psychiatrists."

"Provider enrollment should be based on proving that the provider is qualified to deliver services. The reason we had the community support problem is because many community support providers should never have been endorsed."

Southeastern Regional MH/DD/SA Services

Five staff participated in the focus group meeting. The provider has been in business since 1987, initially provide service to the DD consumers, but later expanded to include mental health consumers.

The participants said they have a good working relationship with the LME, but sometimes the LME needed to await further clarification from the state, so the communication is often delayed. The provider is able to access the psychiatrist from the LME, an arrangement that is important for them, given the scarcity of available psychiatrists in the region.

Specific comments:

"We call the Southeastern Regional staff, and they return our calls, even when they tell us they can't give us an answer."

"We average one admission per month to Cherry Hospital. It would have been worse without the crisis center."

"The LME provides good technical assistance to us. We also get along with the county government."

Comments from contracted providers outside the LME area:

"Southeastern Regional has a good UM system and we are paid on time. They use CareLink to notify us."

Wake County Human Services

Fourteen staff, representing different program and clinical staff working with three disability groups, participated in the focus group meeting. The provider is an established provider with decades of experience in North Carolina. It offers comprehensive provider for all three disability groups covering eight LME areas. Overall, the participants felt positive about new services that have been made available since the new service definitions went into effect; however, they seemed frustrated not only with different process and procedures used by seven other LMEs for IPRS authorization and payment, their own LME, Wake, has added more county rules, e.g., completing "fee application" for each referral to obtain available co-payments, which can delay consumer entry. It takes them two months to receive authorization and still more months to get paid. Regarding Medicaid authorization and payment, their complaints were numerous. In addition, the provider felt that given Wake's own retainment of certain programs and services as county-run programs, referrals to this provider have not been forth coming.

Specific comments:

"It's extremely wasteful to spend valuable professional time completing cumbersome forms which should be simplified, such as PCP and NCTOPPS."

"There is no continuum for individuals with substance abuse needs or individuals with serious and persistent mental illness. We need a longer-term services option beyond short-term interventions."

"Achieving consistency across the LMEs should be a high priority."

Comments from contracted providers in other LME areas:

"Wake is the worst in processing claims. We were told that four county departments had to be involved to approve the payment, even when the check has been cut. We found out

once that the check was kept in a drawer waiting for another layer of approval before we could receive it."

Western Highlands Network

Five staff participated in the focus group meeting. They are pleased with the support from the LME, but felt that there is a general lack of understanding of the clubhouse model—too many programs call themselves "clubhouse" that they have not met the fidelity test.

They are concerned about the documentation requirement for psychosocial rehab, especially the "daily notes" required. The provider has spoken to CMS central office and was told that this is a state rule, not mandated by CMS (this needs to be verified; could be placed by the CMS regional office in Atlanta).

Comments from contracted providers in other LME areas:
"I would rate Western Highlands as one of the top LMEs in paying their claims on time."
"The staff there are always willing to trouble shoot for us."

* * *

An Acute Care Hospital

A regional acute care hospital provider was added to the provider sample to explore the following:

- Interaction with LMEs and other community acute care hospitals
- Flow of referrals to state psychiatric hospitals
- Major barriers to emergency and acute care for consumers with mental health, developmental disabilities, and substance abuse services

This provider was chosen because there have been very few admissions to the state hospital in almost a year. Their management of emergency and acute care in the community could offer insight to all LMEs.

Eight staff participated in the focus group meeting, including staff responsible for mobile crisis and off-hour on-call, nursing and social work staff from the inpatient unit, business office staff, and behavioral health senior management.

The behavioral health division works closely with the LME in developing diversionary services and indigent care at the inpatient unit. They have several contracts in place and consider it one of the chief reasons they have managed to avoid admissions to state hospitalization. However, they expressed frustration with the barriers to intermediate care beyond acute care in that the state hospital would refuse admission to someone already in an acute inpatient bed when the hospital is willing to serve the patient until the acute phase is over.

They have avoided admissions to the state hospital by providing medication titration during the emergency room visit. One challenge is with the sheriff's department: local law enforcement personnel felt burdened when waiting in the emergency room with the patient until the case disposition is settled. Another challenge is DD consumers that have behavioral problems in the emergency room. The hospital works closely with the LME to use other available crisis services, but there is a shortage of crisis stabilization, emergency respite capacity.

The burden of paperwork was cited as one unpleasant feature of doing business with the public system. The hospital staff produced a Regional Referral Form for Admission to a State Psychiatric Hospital or ADATC (Form No. DMH 1-73-00, revised 12/07) and said completing all the items on the form is not always possible during the emergency phase, and that there is no guarantee that the admission request would be accepted. On several occasions the provider has solicited support from the LME to complete the process.

The participants also cited the PCP document as another barrier to services for consumers, especially those who in an acute phase. The paperwork burden overall has added to the cost of doing business.

In terms of interaction with other community hospitals, this hospital uses the regional network and accepts overflows from other LME areas. The participants indicated that at a recent regional hospital providers meeting, other hospital representatives shared their deep frustration with their local LMEs regarding poor communication and serious lack of collaboration. “Unlike us, they are desperate for help.”

VI. Summary of Findings

Feedback from consumers and providers about individual LMEs shows some statewide trends. These trends can inform policymakers in developing strategies to take the system reform to the next phase of implementation. Seven years into the reform implementation, taking a pulse on "how things are" on the ground, where consumers meet providers, can offer real lessons on which adjustments to the system transformation can be made. In other words, the evaluation is not so much to find fault with the implementation effort as to be assured that future activities will achieve the intent of the reform—to develop competent and qualified providers to serve consumers in need while improving public accountability.

Seen in this light, much can be said about the positive tenor of consumers interviewed, and the praise of diligent efforts made at the LME and state level. The problems identified throughout are not insurmountable, and there is some degree of confidence that if the public partners put their mind to it, solutions can be found.

Finding One: With few exceptions, consumers receiving services are generally pleased with how the services have improved their lives. However, adult consumers with SPMI or needs for substance abuse services continue to have access problems.

Many participants in the consumer focus groups have expressed their satisfaction with the services received and have reported positive experiences in being treated with dignity and respect. Some of these consumers are recipients of psychosocial rehabilitation and ACT, and others of the CAP-DD program. However, based on interviews of consumers with substance abuse, accessing community-based services, ranging from intensive outpatient, to community detoxification, to long-term rehabilitation, remains problematic. This is owing to insufficient a qualified substance abuse workforce and lack of funding (other than state and local funds) to develop these services.

Finding Two: Consumers have identified service gaps in supported housing, supported employment, psychiatric services, and crisis interventions that can help to avoid out-of-home placement for children and hospitalization for adults, including such services as in-home crisis stabilization, emergency respite, mobile crisis team, and 24/7 availability of crisis response.

When queried, consumers have reported their own comfort in reaching out to their primary therapist or case manager as the first contact in time of need, and they have continued to use informal support from family and the community at large. Even when consumers are satisfied with the services they receive, they report these gaps as real and of long standing. A telling point is that many consumers have stayed in the same program for more than a decade and have not seen improved life circumstances.

All consumers are dissatisfied with the meager time they now spend with their psychiatrist or therapist. Where medication management is provided, there is concurrent need to be educated about medication effects and side-effects; some programs have done better than others.

Finding Three: Providers are more receptive to serving Medicaid-eligible consumers than consumers with IPRS funding. Many providers have chosen not to serve IPRS funded consumers, and this trend is disturbing.

The reform articulates the responsibility of the public system to serve the targeted populations as defined in the state plan, while ensuring a floor of core services for all citizens at the local level, based on available state and local resources. However, during the site visits this consultant made the observation that many consumers served by the providers do not meet the priority criteria set by the state, partly owing to the easier access of these Medicaid-eligible consumers, partly owing to a provider-based selection process (given the same Medicaid eligibility, consumers with lesser needs might be served first). Other reasons include:

- The barriers at the LME level to have IPRS services authorized as a result of stringent thresholds, inconsistent practices among LMEs, and less-attractive benefit packages.
- The delayed payment of IPRS-funded services, a common problem with the providers; only a few LMEs have improved the payment process.
- The lack of a neutral broker or consequences of refusal when consumers are denied services. There are individual interventions at the LME level, but there are also LMEs that choose not to intervene.

This initial finding should be further verified by hard data in order to answer the question: Does the increased number of consumers since the reform represent a concurrent increase of access for the state's targeted population in both Medicaid and non-Medicaid funded services?

Finding Four: Providers have praised the LMEs for timely communication, provision of training, and technical assistance. Providers that serve primarily a single LME area tend to be more satisfied with the LME's practice. However, providers covering multiple LMEs have universally expressed their frustration with inconsistency and lack of standardization among LMEs in endorsement, IPRS authorization and payment, and provider monitoring.

There is a small but nonetheless significant number of providers that have made strategic decisions to remain local, and to work exclusively with one LME. This group of providers has developed and sustained a good working relationship with the LMEs and has described the relationship as collaborative partnership. Those dissatisfied tend to be in LME areas where the LMEs continue to provide an array of services that might be perceived as being in competition with the providers, or where the providers felt preferential treatment in favor of other providers existed.

This by far is the most striking finding from provider feedback, especially those with a network that covers multiple LMEs. The lack of standardization is described as the result

of LMEs adding requirements beyond the state requirements, including individual staff inconsistencies from the same LME. The inconsistent LME practices that affect the providers the most are:

1. In access, the LME may perform or contract out STR function to another provider, and in some cases inadvertently create a conflict of interest for the provider responsible for the STR or the referrals from a different provider for crisis and emergency services. LMEs also deal with follow-up functions differently.
2. In IPRS authorization, LMEs establish their own thresholds for prior authorization and continued service authorization. Managing different protocols has been challenging and costly to the providers.
3. Providers are burdened with different IT systems used by the LME, and this is further compounded by the lack of web-paged authorization from Value/Option, inefficient transmittal of paper documents from providers to Value/Option, and poor follow-up from Value/Option.
4. With very few exceptions, LMEs perform full endorsement of their contracted providers in other LME areas instead of accepting the findings from the LME where the provider is located.
5. Provider monitoring is practiced with different protocols. In addition to LME monitoring, providers are concerned about the multiple entities that conduct provider monitoring with little coordination among them.
6. Inconsistency can also occur in the individual interpretation of state rules by individual LME staff.

Finding Five: Providers are concerned about the paperwork requirements placed for access to be completed, services to be authorized and reauthorized.

The recurring concerns about the burden of paperwork and the focus on the specific forms used are quite common among the providers in the focus group meetings. The disputed paperwork requirements are:

- The PCP form (initial and full) is cumbersome and an obstacle to getting consumers into services, and some accreditation bodies have questioned the legitimacy of the form
- NCTOPPs form for tracking targeted populations (initial, three-month, six-month, and annual)
- STR form (original and revised version)
- Admission form to the state hospitals

These concerns cannot be verified without bringing other parties to the table. Given the lack of accountability for some community support providers, the problem of PCP implementation seems to be centered on community support providers not producing the PCP document to enable referral to other services.

VII Observations

This consultant, having staffed the Joint Legislative Oversight Committee that led to the passage of the reform legislation HB 381, has some insight into the intent of the reform. Thus observations and questions posed in this section deal with general issues related to the reform itself.

It is now commonly understood that the reform has created a large provider network and attendant service capacity. The number of consumers served in the network has increased exponentially. Many new consumers have entered the system, and some new services, such as crisis services and ACT, have benefited consumers in need. With the conclusion of postpayment audits and full-endorsement reviews of all providers, the picture is now clear—many providers have incurred large fiscal penalties, some have lost their endorsement or folded their business, and yet some have also been fully endorsed and become proficient in delivery of services. This is a necessary phase of correction.

In one respect, what this series of on-site reviews showed is unsettling: many new consumers entering the public system could not be considered the state's priority populations, and that while the services seemed to be well received by the users, it is also possible that other consumers with more complex needs may have been denied services. A quantitative review of all targeted consumers served in both Medicaid and non-Medicaid would be necessary to confirm whether the state's priority consumers have also had increased access to services.

Another observation is the absence of evidence-based practices (EBP) that were supported by the state's new service definitions. The development of ACT programs, intensive in-home intervention, MST, and so on, has not kept pace with the need. In areas where ACT team is available, referrals from the clinical home (community support) are often lacking. Even well-established psychosocial programs suffer lack of referrals from the clinical home. One may speculate on the lack of EBPs—insufficient competent

and qualified providers, cost of delivering services, and lack of training in EBPs in the provider network—could all be contributing factors.

It is also striking that many providers have chosen not to serve IPRS-funded consumers, or only a small portion of them, in order to have Medicaid business. This is an understandable business decision given that the Medicaid benefits are more attractive than IPRS benefits and the hurdles of getting authorized for the former are fewer than for the latter. However, the public system needs to question both the trend and the practice and ask: What can be done about it? At a minimum, the LMEs with service management responsibilities should be at the forefront of ensuring access to the priority populations, and barriers to IPRS authorization and funding should be quickly removed. Furthermore, the use of contracting authority and the proactive use of trend data to monitor and influence provider behaviors should also be considered. There is an impressionistic observation that many of the SPMI consumers could be eligible for Medicaid and are not. Provider staff have related the barriers stemming from lack of coordination between Social Security Administration and local social services departments. This may be a systemic problem that awaits further investigation

How the state psychiatric hospitals and developmental centers interact with the LMEs and community providers is not part of the review; however, the discussion with an acute hospital during the site visit amply demonstrates that there is a need to have a serious dialogue with the state hospital and developmental center directors. State-operated services should be integrated with the community-based services, and there should be a shared future for all.

On a final note, system transformation is a long and arduous process. Building a qualified and competent provider network—as well as building qualified and competent LMEs—all takes time. The immediate question facing the public partners is how to make improvements in an environment with mounting pressure to right the course while uncertainty about a future direction continues. It is not useful to revisit all the problems that brought about the system reform in 2001, or even persist in claiming that some of the

problems still remain. It is more beneficial, and ultimately more productive, for all stakeholders to use lessons learned from the implementation experience to chart a future course. The public system needs qualified and competent providers to serve consumers in need, and the state needs strong partners in counties and regions to manage the public system. The future scenario could include those LMEs that, after a few years of implementation, have discovered their true identity as providers, not managers. There should be a place for them to return to the provider status while allowing others to assume management functions, so that their talent and resources of the workforce can be preserved to serve consumers. Concurrently, the public system should consider offering incentives to promote mission driven providers, public and private, that are interested in the call to public service, so that there will be improved access for consumers with complex needs. In offering different options for participants in the next phase of system transformation, the public partners can usher in a future where there is a place for competent system managers and providers and where consumers served by the system receive results-oriented services, no more and no less.